Cincinnati Public Schools

Authorization for Administration of Over-the-Counter Medications at School

This form expires at the end of the current school year.

_____ _____ _____
Student's Name Date of Birth School Year

_____ _____ _____ _____ _____
Street Address Apt. No. City State Zip

_____ _____ _____
School Grade Homeroom

As this student's parent/guardian, I give permission for my child to receive the following over-the-counter medications during school hours or during after-school activities. I agree to provide the medication my child needs in the original labeled container with the protective seal intact.

(Circle yes or no for each medication listed below. *Physician to complete dosage and time/frequency)

Over-the-Counter Medication (Parent to Complete)	**Circle**		**Dosage (Physician to complete)**	**Time/Frequency (Physician to complete)**
Acetaminophen (Tylenol) for headache, toothache or minor pain	Yes	No		
Ibuprofen for headache, toothache, minor pain or menstrual cramps	Yes	No		
Anti-itch cream or lotion	Yes	No		
Cough drops	Yes	No		
Tums (antacid)	Yes	No		

Is student allergic to any medications? ☐ No ☐ Yes, allergic to _____

Severe reactions that should be reported to the physician: _____

Student's Provider (Physician / Nurse Practitioner / Dentist) *Complete dosage and frequency above.

Provider's Signature: _____ Date: _____

Provider's Name: _____ Emergency Phone _____

I give permission to the Cincinnati Health Department school nurse or Cincinnati Public Schools' designee to give my child the above-mentioned medications for comfort measures. I further agree to indemnify or hold harmless the Cincinnati Health Department or Cincinnati Public Schools and its agents from all claims as a result of any and all acts performed under this authority. I will inform the school if there is a change in any of this information.

_____ _____
Signature of Parent or Guardian Date

_____
Please Print Name of Parent or Guardian

How can we reach you during school hours?

_____ _____ _____ _____
Work Phone Cell Phone Home Phone Other

Cincinnati Public Schools

Over-the-Counter Medication Record 2018-19

FOR OFFICE USE ONLY. Use one form per Over-the-Counter Medication.

Student's Name: _____ Weight: _____ Date of weight: _____

Medication: _____Dosage:_____ Route:_____ Frequency:_____

(No Students days are GRAY on this calendar.)

AUGUST 2018				
Mon	*Tues*	*Wed*	*Thurs*	*Fri*
		1	2	3
6	7	8	9	10
13	14	15	16	17
20	21	22	23	24
27	28	29	30	31

SEPTEMBER				
Mon	*Tues*	*Wed*	*Thurs*	*Fri*
3	4	5	6	7
10	11	12	13	14
17	18	19	20	21
24	25	26	27	28

OCTOBER				
Mon	*Tues*	*Wed*	*Thurs*	*Fri*
1	2	3	4	5
8	9	10	11	12
15	16	17	18	19
22	23	24	25	26
29	30	31		

NOVEMBER				
Mon	*Tues*	*Wed*	*Thurs*	*Fri*
			1	2
5	6	7	8	9
12	13	14	15	16
19	20	21	22	23
26	27	28	29	30

DECEMBER				
Mon	*Tues*	*Wed*	*Thurs*	*Fri*
3	4	5	6	7
10	11	12	13	14
17	18	19	20	21
24	25	26	27	28
31				

JANUARY 2019				
Mon	*Tues*	*Wed*	*Thurs*	*Fri*
	1	2	3	4
7	8	9	10	11
14	15	16	17	18
21	22	23	24	25
28	29	30	31	

FEBRUARY 2019				
Mon	*Tues*	*Wed*	*Thurs*	*Fri*
				1
4	5	6	7	8
11	12	13	14	15
18	19	20	21	22
25	26	27	28	

MARCH				
Mon	*Tues*	*Wed*	*Thurs*	*Fri*
				1
4	5	6	7	8
11	12	13	14	15
18	19	20	21	22
25	26	27	28	29

APRIL				
Mon	*Tues*	*Wed*	*Thurs*	*Fri*
1	2	3	4	5
8	9	10	11	12
15	16	17	18	19
22	23	24	25	26
29	30			

MAY				
Mon	*Tues*	*Wed*	*Thurs*	*Fri*
		1	2	3
6	7	8	9	10
13	14	15	16	17
20	21	22	23	24
27	28	29	30	31

JUNE				
Mon	*Tues*	*Wed*	*Thurs*	*Fri*
3	4	5	6	7
10	11	12	13	14
17	18	19	20	21
24	25	26	27	28

Signatures:

_____ Initials _____

_____ Initials _____

Signatures:

_____ Initials _____

_____ Initials _____